

Domesticating insurance, financialising family lives

The case of private health insurance for children in Finland

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Abstract

This article explores the domestication of a financial instrument that is much used in contemporary Finland, but that most of its users do not primarily think about in terms of being a financial instrument: the private health insurance for children. In Finland, all children are covered by social insurance and are entitled to free public health service. Yet, some 40% of families want to supplement this service with private products. Many fear that the popularity of the private health insurance for children contributes to a vicious circle that ends up weakening the legitimacy of, and the service given by, the public health sector; inequality in the face of health risks threatens to be aggravated, as well. Therefore, this financial instrument has become an object of political controversy. The main question of the article is: how do economic, political and moral valuations become intertwined in the domestication of insurance? The concept of 'domestication' is found helpful for analysing the pragmatics of valuation and for appreciating the dynamics and the heterogeneity of forces at play when financialisation influences everyday life. The study argues that when financial instruments are appropriated they are also transformed; thus, they should not be viewed as homogeneous tools that have similar effects in all contexts of use. Yet, emphasising the activity of the people involved in domesticating the products on offer does not lead to downplaying the influence that it has on them. Rather, the case study shows how, concretely, the use of a financial product can have an effect on welfare institutions, and how families'

everyday life is rendered into something that insurance companies and private health centres can capture, become attached to and control. The main empirical materials studied are interviews with parents with and without private health insurance policies for their children.

Keywords

Financialisation; Domestication; Health Insurance; Insurance; Children; Welfare Society

Introduction

One of the central questions of social sciences has concerned the increasing significance of money and economic rationality for the way of life. This question has become more urgent in recent decades with the growth of global financial flows, and the proliferation of means with which everyday life is economised. An influential scholarly response to the situation has been the emergence of the new social scientific interest in finances, which has produced rich and detailed examinations of related practices and institutions (seminal texts include Callon 1998; Callon et al 2007; Knorr-Cetina & Preda 2005; MacKenzie 2006; 2009; MacKenzie et al 2009; for an overview of the field, see Carruthers & Kim 2011). In contrast to studies that concentrate on the practices of financial institutions, another reaction has been to pay more attention to the ways that lay people are affected. Thus, by now there exists a substantial amount of literature on the 'financialisation of daily life' (Martin 2002; see also e.g. Adkins 2015; Allon 2015; Deville 2015; Langley 2008; Lazarus 2012; Montgomerie 2013; Weiss 2015). The study at hand draws from these works, but it presents a slightly different emphasis as it scrutinises how the financial sector is intertwined with households' everyday concerns and practices that, at face value, have very little to do with finances.

This article examines the domestication of a financial instrument that is much used in contemporary Finland, but that is not primarily thought of as a financial instrument by most of its users: private health insurance for children. This case is interesting because taking out private insurance for the child is not only a widespread practice in Finland but also an object of political controversy. Moreover, its popularity is having effects on the public health care system supported by the welfare state.

I will argue that the domestication process transforms the financial products appropriated; these should not be viewed as homogeneous tools that have similar effects in all contexts of use. A related point has recently been made by Pellandini-Simányi, Hammer and Vargha who have described how financial products are 'appropriated to existing relationships, temporal structures and rationalities that guide everyday life' (2015, p. 753). In line with their argument, I will claim that the process of domestication affects all parties that are involved in it, and that it has to be seen as multidirectional. In other words, to emphasise the activity of the people involved in appropriating the products on offer does not lead to downplaying the influence that it has on them. Namely, the use of financial products strongly shapes both welfare institutions and families' everyday life. To capture these directions and effects on multiple scales, it is of crucial importance to pay close attention to the specific ways in which financial instruments *test* their users and institutional settings. Simultaneously, these users also valueate, define and put on trial the capabilities of the financial products and various health services, and thus, transform them.

In Finland, all children are covered by social insurance and are entitled to public health service for free. Yet, many families want to supplement this service. At present, some 40% of children under 7 years are insured privately. There is a strong correlation with income; in the lowest quintile, approximately 90% of the population is without private policies. An insurance policy compensates for the costs of using private health services and drugs. As accident insurance is usually attached to the product, in case of long-term problems or invalidity, the insurance policy will also help to compensate and cover costs that the welfare state will not. Most relevant for the families, however, is the access to private doctors and

health services that are perceived as being of better quality and convenience compared with those provided by the public sector. Still, even when families have taken out a private insurance policy, cases of illness or injury that are more serious are nearly always treated in the public special health care. Thus, the welfare state in Finland functions as the backup health service provider and insurer, as it were, even for the clients of private insurance companies and health centres.

The starting price of an insurance policy for an unborn is approximately 350–400€ for the first year, and the cost diminishes annually. Deductibles are around 100€ per year. In comparison, the normal rate for a single consultation with a private doctor starts at approximately 60€, and the price to see a specialist can be double. Therefore, a simple calculation reveals that for the price of an insurance policy, and without its cover, one could see a private doctor multiple times a year. In other words, if you take out a private insurance policy, you make two decisions. First, you think that you need more or different services than what you get for free at the municipal health centre. Second, you guard yourself against having to use private health care more than at least three to six times a year (depending on whether you think you are going to need the services of a general practitioner or a specialist). Put in these terms, it is perplexing why people would opt to take out private health insurance policies for their children in Finland. Yet half of the middle-class families do.

This article examines what is behind the popularity of the product. Underlying that question is a more general interest in the ways in which financial instruments affect everyday life. In the present case, the narrowly economic calculations implied by a financial technology are intertwined with a series of other kinds of considerations. The latter include things such as family tradition, love and moral responsibility; convenience in the midst of harried working life; and political convictions. This series of everyday concerns that are, to an extent, non-economic, intersect with a completely different set of considerations: those by the insurance company, its centres of calculation, financial strategies and operations. To sum up, the article asks what kinds of relations are involved and activated in the

appropriation of a specific financial instrument. How do economic, political and moral valuations and everyday practices become intertwined in the domestication of private health insurance for children?

Financialisation of daily life and the new sociology of insurance

While the present paper draws from the already existing literature on the financialisation of daily life, it also departs from these texts in a number of ways. To begin with, much of the best writing on the issue is primarily concerned with debt and credit. Given the huge importance of debt to the current political economy, on all scales – ranging from individuals, families, small businesses and municipalities to state budgets and global corporations – this emphasis is well-warranted. For the households' daily life the question comes up in terms of labour and mortgages (e.g. Adkins 2015; Allon 2015; Bryan & Rafferty 2014; Martin 2002; Montgomerie 2013; Weiss 2015), pension security and saving (e.g. Clark 2005; Montagne 2007) and consumer credit (e.g. Deville 2012; 2015; Lazarus 2012; Montgomerie 2006). All of these themes are to an extent studied in the landmark publication by Langley, *The Everyday Life of Global Finance* (2008).

Yet, saving, debt and credit are not all there is to everyday life and finances. What makes insurance particular as a financial instrument is that from the point of view of the insured it is not primarily about 'leveraging' monetary potential, of making use of the future uncertainty (Allon 2015). To an extent, the logic of insurance is the exact reverse of the logic of debt and credit, as it implies paying in the here and now in order to guard oneself against vulnerabilities and uncertainty in the future.

Although insurance as a topic has thus far received less attention among scholars than it merits, there does exist much valuable literature in this theme area as well. Indeed, it is possible to talk about the new sociology of insurance, a line of research where some of the early impulses have come from the Foucaultian studies by Ewald (1986), Donzelot (1991) and Castel (1991). These works show the importance of the insurance rationality for how contemporary societies problematize uncertainty, and

how governance operates through the management of risk in its many guises and in multiple scales (see also Baker & Simon 2002; Ericson et al 2003; O'Malley 2004). This literature, however, does not say much about the role of insurance in the financialisation of daily life. In this respect, closer to the aims of the present article is the path-breaking book by Zelizer (1979) and, especially, the study by McFall (2015).¹ Yet, all of these works are historically oriented and, even more significantly from the point of view of the present article, emphasise the production and selling of insurance policies; this is also true of the valuable ethnographies that have been conducted on the insurance industry (Ericson & Doyle 2004; Van Hoyweghen 2006; 2014). Not enough is said about the concrete practices in which people *acquire, use and live with* the insurance instruments.

To sum up, there are a number of points of divergence the present article has with the previous studies on financialisation of daily life and insurance. First, in this literature the emphasis tends to be on the side of production, dispersion and structural effects of financial instruments. Their actual use in daily life has got less empirical attention.² Second, there has been a tendency to focus on saving, mortgages, credit and debt; insurance as a topic has been left a bit in the shadows. Third, as regards the existing literature on insurance, much of it has an historical emphasis; little has been said about contemporary practices of acquisition and use. Fourth, one of the original accents of the present paper is how in the everyday lives people use financial instruments that they themselves do not primarily – if at all – think about in terms of being financial. Finally, to add one more item to the list, most of the literature quoted above is on the Anglo-American societies, where the tendencies of what has come to be known as neo-liberalisation are perhaps at its strongest. In contrast, studying families' practices related to child health care in Finland offers a different kind of case. Here, a strong Nordic welfare system is in tension with private service-providers, and households negotiate their relationship to these different sectors, while guarding themselves against the contingencies of life.

¹ For my own research in this vein, see Lehtonen 2014; Lehtonen & Liukko 2010.

² However, this seems to be changing, as evidenced by the studies on lay people's encounters with financial instruments by Lazarus (2012); Olcon-Kubicka and Halawa (2015); Pellandini-Simányi et al (2015) and Weiss (2015).

In the next two sections, I will first present the key conceptual background of the study, and then, briefly describe the data used. After that, I will examine in more detail the empirical findings. In the ensuing sections, I first look at the process of choosing to have an insurance policy and how the choice relates to existing social relationships and conventions. This is contrasted with the arguments presented by those people who prefer not to take out an insurance policy for their child. Then, I move on to study how the domestication of this specific financial technology implies multiple scales of practice. The final empirical section of the paper discusses the reasons why insurance companies, for their part, find the product useful. The claim is that while families use it for managing everyday life, it at the same time domesticates families to become tame participants in the financialised form of life.

Domestication as a set of trials

A key concept for my analyses is that of 'domestication'. Most often the word refers to animals that have become accustomed to 'live under the care and near the habitations of man [sic]; to tame or bring under control' (OED). Something that has previously been alien to the domestic sphere is little by little made to become a familiar part of it. In the social sciences, the term has been employed in studies on the ways in which households acquire and learn to use new technologies. In the influential work of Roger Silverstone and his colleagues (Morley 2003; Silverstone 2006; Silverstone et al 1992; Silverstone et al 1996), emphasis has been put on what they call 'the moral economy of household'. Silverstone and others have called attention to the activity of people in maintaining and ordering their everyday worlds, and in the creativity implied by the process of appropriating new technologies. While linking my work with this research tradition, the particular emphases of my study are different. They are twofold. First, I want to stress that domestication is a two-way street: not only does it mean that the object that is being domesticated is appropriated and made part of a household's way of life; in addition, it means that the people using the particular technology are themselves modified by it. In this I follow Michel Serres' (2001, p. 105) insight that the neolithic domestication of animals has also been a learning process for

human beings: they have learned to live with, and even under the same roof, with cows and sheep; consequently, their food culture and daily habits have been thoroughly transformed by their living with other creatures. Thus, the term 'domestication' implies that one *learns to become affected in a new way by one's environment* (see also Callon 1986). In relation to the theme of this study, the question is, then, how are households themselves affected by the process where they domesticate financial instruments? How are these instruments that at first sight seem alien to the domestic sphere – even alienating – become seen as familiar and self-evident parts of it?

Second, I want to highlight how domestication can be studied as a *set of trials* (Lehtonen 2003). As the domestication literature in general has made clear, appropriating a technology is not simply a linear process. Instead, it can consist of multiple phases that overlap. What I will emphasise, using empirical material, is that these phases can be seen as structured by trials where both the technology and its users are tested and, through the testing, transformed. Importantly, there is no point in expecting the trials to be the same with all technologies or with all users. Rather, the conceptualisation allows for sensitivity toward the heterogeneity of practices.

As regards the concept of trials, I draw on two bodies of work, that produced by Bruno Latour (e.g. 1987; 1999; see also Callon 1986) and that by Luc Boltanski and Laurent Thévenot (1991). According to Latour, trials are 'experiments of various sorts in which new performances are elicited' (Latour 1999, p. 311). Especially in his early work, Latour has underscored the role of trials as tests of *strength*: what is made stable is an assemblage of forces that constantly pass the trials of strength in terms of being able to stick together (e.g. 1987, pp. 78, 92). In the case of an insurance policy, it is tested when its effects are evaluated: does it really bring about something positive for a family, and if yes, what precisely? Does it have the force to be attached to the family life for good? Simultaneously, as will be seen later in this paper, the adoption will test the household, for instance as regards its economy or its members' relationship with the welfare structures. Although their conceptualisation is compatible with the work of Latour, Boltanski and Thévenot (1991) highlight an important additional aspect. According to them,

trials are typically about *valuating*; they can be used for judging the qualities of the participants.³

Relatedly, trials as events where things are valued are also at the root of the possibility to *criticise* either practices or institutions. As the next sections of this study will show, the element of criticism is central for the discussions concerning the private health insurance for children.

Empirical materials

The primary materials studied in this study are interviews with people who have taken out private health insurance for their children, and with people who have not. My analyses concentrate on the findings from six focus-group interviews conducted in October and November 2013. Each interview lasted from one and a half to two hours. The participants were from the greater Helsinki region. Of the 45 interviewees, all parents with children, 18 were male and 27 were female. Four of the six groups were with people who have taken out health insurance policies for their children, and two with people who have not.⁴ These materials are backed up by another set of interviews, which consists of single interviews with parents, conducted in spring 2014 in the Tampere region by another research group (Häikiö et al 2017).⁵ In addition, the study uses the background information gathered through my own fieldwork that has consisted of meetings with insurance professionals, participation in public events where the theme has been discussed and following the Internet discussions concerning private health insurance for children.

³ For a case study in this tradition on households testing financial services and their qualities, and being tested by them, see Lazarus 2012.

⁴ I conducted the focus group interviews (except for one that was conducted by Eija Ahola-Hyppönen) in a joint project with the Finnish Federation of Financial Services and Taloustutkimus Ltd.

⁵ The single interviews were conducted by students who participated in the research seminar directed by Liisa Häikiö at the University of Tampere; the interview work was also supervised by Liina Sointu and Lina Van Aerschot. In this project, of the 25 people who were interviewed, 17 have taken out private health insurance policies for their children, and 8 have not. I am thankful for Liisa, Liina and Lina for the opportunity to use that latter set of interviews alongside the ones that I have collected myself, and for the students for their efforts.

The period of hesitation: developing a need with warm experts and (unevenly) distributed cognition

How does one develop a need for a private insurance policy for the child, even when all health services are provided by the municipality for free? For some participants in the focus groups, to put the question in this way is to put it falsely. Instead, insuring the child can be a matter of custom or family tradition. You do not really *develop* a need, because taking out private insurance is self-evident, something that you know you have to do when a baby is coming. In the interviews, this stance is stated in the following manner by two women in their thirties: 'It's a culture in some ways – all of my own childhood I've been visiting a private doctor, I'm used to having private insurance policies, so somehow you continue that.' 'Well, I've also had one when I was a child, and my husband had one, and the friends of the family and their children have. So it's really part of the package somehow.'

Sometimes the self-evidence is further supported by having it easy: it can be the future grandparents who take the initiative on the issue, and not only that, they also take care of the payments to support the young family. 'We got it already when I was pregnant. It was strictly because my mother pushed the issue and provided it for all grandchildren.' What is significant here is that for these people, apparently there is no need to tame this financial instrument, as it is already part of the lifestyle. Private insurance is encountered as something *already* domesticated.

Yet not everybody has a private health insurance policy for the child. As the product costs quite a lot for a young couple, it sounds reasonable to ponder a bit whether the family might as well do without it. Tuuli, a woman in her thirties, says that during the first pregnancy, she and her partner had many discussions 'with people of the same age who had or were about to have children'. Another family played a particularly important role in the decision making. 'Our friends had taken out a policy for a period, then cancelled it because the child never had any [health problems], but then afterwards this child got all kinds of illnesses, even serious ones.' Close acquaintances' experience served to convince the couple that a private policy is needed – although, as Tuuli finally says, even with a period of

hesitation and discussion among the peer group, the outcome was obvious: 'Yes we talked about it a lot. But in our circles, and for our parents too, it's just that you take out an insurance for your home and for the car, so you take it for the humans as well.' Although after the fact, to have taken out the policy seems like the self-evident thing to do, even here there is *a period of hesitation*: other people's experiences of having tested the product are considered.

It is significant that also in cases where taking out an insurance policy for the child is described as the obvious thing to do, this is seldom done alone, without consultations or conversations in the circle of acquaintances. Focus-group discussions are full of remarks and stories about how people have squared others' experiences with their own situation and expectations: 'I have a friend whose son turns six. This son had constantly ear infections or was otherwise ill, and she said that it's good to have an insurance that you can use.' 'Right away when I first got pregnant my sister told us that one definitely should take out an insurance policy.' 'I was also asked by a friend of my husband whether we have an insurance and whether it's worth taking. I said yes, at least in the beginning it's good to have.'

Close friends, siblings with children and other family members are mobilised as 'warm experts' (Bakardieva 2005; see also Lehtonen 2003): they are trusted because they are deemed more knowledgeable. In addition, people can consult social media, the Internet, or paper magazines. 'Distributed cognition' (Hutchins 1995) is used for evaluating whether an insurance policy is needed or not. Domestication is achieved collectively. Yet, the way one's circle of acquaintances is formed matters a lot. One is likely to share the lifestyle and have similar educational background and income level with the most trusted warm experts. Hence, the 'distributed cognition' is not evenly distributed within a nation state such as Finland; the perceived 'need' for the private products to supplement the public health sector develops and is discussed very differently in various social worlds. In the manner classically examined by Bourdieu (1984), what comes 'naturally' distinguishes people from each other and renders mechanisms behind social inequalities seem like questions of individual taste.

Deciding not to take out an insurance policy

Although after the fact the discussions with warm experts can be interpreted as mostly having served to cement a pre-existing belief in the product, as with Tuuli, the period of hesitation can also lead to a negative decision. This is the case with Anu, a 27-year-old student and a mother of two. She and her partner 'contemplated a lot the accident insurance for children when I was pregnant. I was asking everybody I came across about it, even at the bank.' The couple acquired an offer from a company, but in the end, decided not take out a policy. Anu describes the discussions concerning the product intensive. 'People had terribly strong opinions one way or another. Some said that it doesn't make any sense, is it something like 400 euros the first year.' However, others told Anu that if you have trouble early in a child's life, for example, a bad stretch of ear infections, then afterward, you cannot get such an insurance policy that would cover the treatment for this condition. Amid conflicting evidence and opinions, in the end, Anu and her husband decided that 'we take the risk, and we won't get one for our child.'

Similar to many others' stories in focus groups, different sorts of arguments are mixed in Anu's account. It becomes evident that what can render decision making so difficult is that one needs to make a calculus of incompatible things. At least four different reasons can be found for why households will opt not to take out a private health insurance policy for their child. Behind all of them is confidence in the public health care system in Finland and the basic security it provides.

First, if the members of the household do not have experience of using a policy and, especially, if acquaintances have had an experience of regarding it dispensable after having acquired it, no need for seriously considering it arises. Second, economic evaluations can play a crucial role. People can calculate the price of the private policy and compare it negatively to the costs of taking care of health solely on the public side or perhaps making the occasional one-off visit to a private doctor, as well. The significance of such calculations is emphasised by those with lesser means. In the focus groups, especially those who have *not* taken out an insurance policy talk about money a lot. The same applies to

those who have cancelled the contract; in the words of an interviewee: 'There simply wasn't enough money, so we thought that as we haven't had use for it yet, maybe we won't need it later on either.' Kira, a 39-year-old secretary, says that before the birth of the first child, she and her partner contemplated taking out an insurance policy, following the example of her brother who had it for both children. Yet they decided to do otherwise. 'You somehow have confidence that everything is well taken care of on the public side, and there's the money issue too, that's something that you think about as well.' Matti, a 34-year-old part-time student and taxi driver, a father of two, says that the couple never really considered taking out an insurance policy. 'We were so poor as students, living on the home care subsidy, you don't feel like spending hundreds on something like an insurance policy.'

In contrast, it is revealing that those who have taken out a private insurance policy do not usually discuss the strictly economic side of the deal – unless their child has been ill often, and the household has received high indemnities. Of course, the latter is a rare case.⁶

Third, the decision not to take out an insurance policy can be based on the positive experience and judgement concerning the functioning of the health services provided by the welfare state. Matti says that 'we've had to take our younger son to [the Public] Children's Hospital a couple of times, everything's gone really well.' Salla, a woman in her late thirties describes the process in the following words: 'When I first became pregnant and started to frequent the [municipal] prenatal care, I thought it was superb, and the nurse there was so lovely. [...] Then I thought that when I'm so well taken care of now, it's likely that the child will be taken care of as well.' Nina, a woman in her early forties describes how she and her husband at first disagreed about the issue. According to her, the husband is easily convinced by others' opinions, and he assumed that the insurance policy is among the many things that a family simply has to acquire. In contrast, she thought that the private policy is not worth paying for. 'Health care for children is free in Finland, and it works well. [...] I stood my ground, and we didn't

⁶ Not 'getting back' the money the insured pay is a key aspect behind making insurance an effective means for creating economic security; because of the pooling mechanism, only the unlucky ones who encounter harm reclaim what they themselves have paid in premiums or receive even more than that (Baker 2002, p. 36; Lehtonen & Liukko 2015, p. 157).

take it. I've been satisfied, everything's worked out well. [...] If there's a bigger problem, anyway it's the public sector that takes care of it, surgeries and all.'

Fourth, eschewing private policies can be related to a set of reasons that have to do with the existing welfare services on another less practical level: the willingness to support the public sector in addition to profiting from it. Different kinds of arguments related to this can support each other. Some interviewees deem the quality of the public services in Finland as high; others underscore that their availability is a social right that is based on having paid taxes; and some say that it is important for the development of social justice and equality that the public services are as widely used as possible, that is, they think that using them in itself is a form of support. Thus, in the focus groups, people can voice strong opinions about taking out a private policy, stating that it would be a bad decision from a moral and political point of view. 'I said that if we pay taxes, well, then we have to get the care from the municipal health centre.' 'My wife thinks about it really as an ideological issue. [...] She said that if everybody was to use the private side, well then the public side – it is a sort of sign for the public side that it's not worth maintaining if no one uses it.'

A question of scales: is health insurance a private or public matter?

Obviously, for the informants, an insurance policy is not only a simple tool that secures health services; there are more mediations involved than the three partite link between a family, an insurance company and a private health centre. Private insurance is revealed to be a public matter of concern. At the same time, however, it is clear that to differentiate between 'private' and 'public' in this case is not simple. According to the classical definition by John Dewey, those acts can be regarded as private that 'affect the persons directly engaged in a transaction'; in contrast, public acts 'affect others beyond those immediately concerned' (Dewey 1927, p. 12). Acquiring and using private health insurance for one's child is evidently both. If one only pays attention to the act of payment, to one's willingness to provide

the best possible care for one's child, or the customer relationship with the insurance company and the health centre, this is a private matter. However, with the compound effects of many people doing the same thing the whole public health care system is put on trial. Thus, the private matter of people insuring their children can understandably become a source of controversy and very much a public issue as well.

One of the most vocal critics of the proliferation of private health insurance for children in Finland has been a senior officer of the medical establishment, the paediatrician Jari Petäjä. For example, in the winter 2014, he was interviewed on a national TV channel. He claimed that the recent dismantling of the welfare structures has effectively created a situation where to get proper care for their children, especially in the greater Helsinki region, families are forced to take out private health insurance policies. In consequence, those families who either cannot afford these policies or have been left out of the insurance pools for medical reasons face systematically higher health risks. This is in stark contrast to the spirit of the Finnish law, according to which all citizens should be equally taken care of. After the interview, which was also reviewed in major newspapers, a vivid Internet discussion emerged. Although many participants agreed with Petäjä, others insisted that those who can afford to do so should be free to look for better services than what the municipal health centres can offer.

From the point of view of the welfare structures, the popularity of the private health insurance can lead to a vicious circle. Many families believe that they get better service at a private clinic. The public health care system in Finland functions so that one first has to get an appointment with a general practitioner who, if need be, then provides the patient a referral to a specialist; one cannot freely choose which doctor one visits, cannot go directly to a specialist – for example, a paediatrician – and in many cases, cannot reserve an appointment at an exact hour but has to queue a bit, if not in the waiting room, then by the telephone. In contrast, on the private side, one can choose which doctor one visits and more easily gets an exact hour for the appointment; there is very little need for queuing. Further, on the private side, the waiting rooms are cosier than those of the municipal health centres are; they are also

populated by other middle-class patients and their families. Many interviewees with health insurance policies for their children voice horror over the presumed conditions of the municipal health centres, where they, with their sickly and weeping children, presumably would have to wait for ages among drunkards and other asocial or outcast elements of society. Of course, those with actual experience of the municipal health centres tend not to attest to such dreadfulness. However, also for the doctors the private health centres are able to offer advantages: a middle-class clientele that they more easily can relate to, often better pay, and more flexible working hours, as well.

The perceived disadvantage of the municipal health centres easily becomes a self-fulfilling prophecy.⁷ So-called bad risks are left to the public side. Little by little, a dual system emerges. This leads to increasing social inequality: class differences in the access to health care and its quality widen. Moreover, in addition to their private insurance policies, the middle-class families pay, through taxes, for the municipal health care for which they might have quite little use. This can lead to a situation where the legitimacy of the whole welfare system starts to erode.

Thus, while the private health insurance is being domesticated by households, on an institutional and societal scale it becomes a wild beast that can have uncontrolled effects. When the political aspects linked with insurance come into discussion, individuals are aware that their activity has effects on other scales than just that of their households. Of course, this is more generally the case with people who are politically aware of the consequences of their own and others' consumer practices on many scales simultaneously (Miller 2012). They understand that their choices have a broader relevance than just mirroring their own tastes.

Yet, the use of the private policy not only has implications and traverses many scales but also helps to *constitute* and *shape* these scales. This is an important point for the social scientist analysing the case. One cannot simply presuppose the *existence* of scales but must also study the dynamic 'scalography'

⁷ This theme is debated in the Finnish discussion concerning the issue, see Kajantie 2014 and Miettinen et al 2013.

(Pyyhtinen 2015; see also Latour 2005) relevant for the case: what is it that *circulates* between different scales, facilitates links between them, and simultaneously, in part constitutes them?

Obviously, one answer is that *money* circulates between different scales. Households pay the insurance companies who pay the private health centres. Households also pay taxes, and so do insurance companies and private health centres, and thus they all support the welfare state, as well. Nevertheless, money is enacted as a different thing in these scales and connections. It becomes multiple monies (Zelizer 1993). For a family, the payment helps to obtain a tangible and localisable service. However, from the point of view of the insurance company, the fees obtained from the clients are just a minor detail in the broader pursuit of profit. A household's money is transported to a larger pool of investment resources and financial flows that insurance companies manipulate; they manage the health insurance money as part of their more general investment funds and strategies.⁸ Indeed, insurance companies' profits usually result from having invested well the capital that is reserved for future indemnities, not so much from high insurance premiums. Households' payments are moved from the local scale of transactions to the global scale of financial flows.

Nonetheless, as I have already made clear, from the point of view of families, money is just one among many factors that are considered. For example, in Nina's discourse, quoted above, it is evident that to make a decision on whether to take out an insurance policy, you have to take heed of a number of heterogeneous things, test and evaluate their relative importance: your spouse's thoughts and the credibility of his sources of information; whether the existence of queues in public health centres is just a rumour; the question of price and the value of the free service provided by the municipality; the likelihood of ear infections and the quality of the care given in different places; but also how you get treatment if there is 'a bigger problem' and a surgery is needed.

⁸ On households' income streams becoming constituent elements of global financial flows, not only as regards insurance but also more generally, see for example Allon 2015; Bryan & Rafferty 2014; Clark 2005; Langley 2008.

To sum up this section, then, there are two dimensions that make the case of private health insurance for children such a complex issue for families and a matter of concern for the broader society: the *heterogeneity* of elements that have to be taken into account when deciding whether to buy and use it, and the many *scales* upon which it has effects and which it helps to constitute. What seems to be decisive for whether an insurance policy is acquired or not is the answer to the question: which scale is deemed the most important for a particular household, and what kinds of resources does the household have on this scale? In the next sections, I will turn to issues that are most significant for middle-class families, which all centre on the scale of experiencing the everyday life.

Insurance as a mixed object: hierarchical multiplicity of trials

Thus far, I have identified a number of trials that are relevant for the domestication of the private health insurance for children in Finland. To begin with, people test the capability of their relatives and other warm experts to give information on the issue. During the first period of hesitation, they acquire knowledge of whether other families have found private insurance useful, and in which ways, when it has been tried in practice. Is a particular doctor competent and nice? What about the waiting room and queuing? The trials can go in two directions. For example, the waiting room for its part could test the parents' and, especially, the ill child's patience. Furthermore, the household's own economic situation is tested: 400 euros a year, can we afford that? What other things could we do with that money? As regards the value of the private policy itself and the services it makes available, it is rarely tested in isolation, but in relation to public health care. Indeed, the commercial product is necessary only if it is perceived to offer something that the social welfare system cannot provide. Evidently, one visit to a doctor can be a trial of multiple things and scales simultaneously, not only of the experience of a particular doctor's capability to help, but to some people, it can also test the way in which the welfare state is capable of taking care of its citizens. An element of delegation is involved as, of course, the

welfare state is on trial in its totality through the local health centre and its practices, and as families listen to others' experiences of having tested the services available.

Significantly, what determines the direction a family is going to take on the issue is not the result of any single trial. Instead, decisions are based on the *combination of and hierarchisation* between different tests and between respective justifications for one's actions. In listening to those who base their reasoning against private health insurance on an ideological or political conviction, it seems that the most important trial would not test private insurance nor the municipal health infrastructure. Rather, the important trial concerns *oneself*: do one's own actions help to maintain the welfare state or social justice?

Yet, amid heated debate on equality, many families find the instrument provided by the insurance companies inviting. In this section, I will concentrate on a heterogeneous set of criteria most important for families that have taken out a private insurance policy for their child: convenience, security and moral responsibility.

Convenience and time management

A key concern for many families who use private health services is convenience, in two ways: a private health insurance policy gives families direct access to a paediatrician or other specialist, instead of having to first meet with a general practitioner; in addition, private services allow for better time management than the municipal health system does. Let us take the example of Marjatta, a forty-year-old single mother, who is employed by an international corporation in a senior position. With a harried working life, economic constraints given by the mortgage, but also willingness to be the best mother she can be for her nine-year-old daughter, the insurance policy and private health care offer her the kind of flexibility that she is willing to pay for. If her daughter gets ill, she wants to have the exact knowledge of the consultation hour with no need to queue for it, and be able to arrange for the help for the rest of the day. Furthermore, in contrast to the public side, a private health centre can offer a consultation hour for the evening, when Marjatta has fulfilled her many duties at work. With the help

of the insurance policy, Marjatta manages to balance her ambitions at work with that of being a responsible mother. Such considerations are typical of middle-class families where time is scarcer than money is (Southerton 2003). The most important feature that the private insurance policy offers for Marjatta, and for most of its users in organising everyday life in relation to a child's health, is the flexibility that otherwise would not be accessible.

In the public discussions on private health care for children in Finland, the *queue* has become the symbol for everything that is wrong with the welfare services provided by municipalities: the time wasted by people waiting and, simultaneously, officials' incapability to make services run smoothly. In addition, as described previously, it connotes crowded waiting rooms with nervous and unpleasant masses of people and, perhaps even more annoyingly, waiting in a telephone queue to reserve an appointment.

Security

For most people, the self-evident purpose of taking out an insurance policy is to create and obtain more security. Getting pregnant for the first time implies a great change in one's life, and it also increases the feeling of uncertainty in facing the future. Hence, the parents' willingness to do everything in their might to create as much security for their child as possible is tested, but also the welfare state's services and private actors' products are put on trial as regards their capability to generate security.

In the interviews, an often-repeated line is that an insurance policy is taken out 'in case something happens.' It has the capability to tame chance to an extent. Yet, in practice the private health insurance policy for children gives very little if any benefit in terms of standards of medical care; rather, it is primarily a device for creating convenience. It appears that for many families this is not clear. For example, Anne says, 'we thought that if something goes wrong when giving birth, it would bug us to have to wait a long time for the care that we would need to have rapidly'. In the hypothetical case imagined by Anne, the private policy would not in fact make a difference in the quality of care that

would be provided by the public sector anyway (in Finland, nearly all birth clinics and the related health care are funded by public means similarly to most other forms of special health care). Another interviewee, Mari, explains her and her husband's choice of taking out an insurance policy in the following manner: 'I thought that it's there for the sake of security even if it was not much used. I feel that it sort of provides security when you know that if I get worried over something we'll have the access to medical examination almost immediately, so that I don't have to think twice. You hear stories that [the municipal health care] doesn't always function so well.' Lack of confidence in the public system can come out very clearly in the interviews. Nevertheless, the more precise understanding of *how* exactly the private policy will help in case something unfortunate occurs, often remains fuzzy. What taking out an insurance policy certainly gives for the future parents, then, is the *feeling* that one has done all that is in one's might to guarantee as much security as possible.

More generally, in the interviews it is evident that the principles that guide insurance companies' operations are not given much thought, and people do not mind remaining quite ignorant in this respect. In contrast, from the point of view of the insurance company, a private insurance policy for a child is a very technical instrument. The liabilities are strictly limited by a contract, and they only concern economic coverage. Moreover, behind an insurance policy there are exact calculations related to various sorts of risks within a strictly defined population, including those related to accidents and health, but also risks related to the functions of private health centres and risks related to the financial markets. In its operations, an insurance company is fundamentally dependent on the use of various kinds of technologies of risk and precise calculations.

As regards access to information and capabilities of calculating, there is a strong asymmetry between insurance companies and their clients (Van Hoyweghen 2014). Of course, even for those who have taken out an insurance policy, calculations of price matter, but much less so than valuations regarding convenience and security do. Making calculated assessments of risk (and not simply price) is even less usual. Thus, whereas for the companies 'risk' is a technical category and at the core of the business, for

the customers the concept is not very important and is certainly not clearly defined. It is revealing that the concept of 'risk' very rarely comes up in the interviews on insurance if not probed for.

Pat O'Malley (2004) makes a useful distinction between 'technologies of risk' and 'technologies of uncertainty.' Whereas the former depend on exact knowledge of data and calculations concerning aggregated futures, for the latter, these are lacking. Yet practices such as bank saving can still be *technical*, although they are not based on precise calculations. This distinction is helpful in the case of private health insurance for children in Finland. On the one hand, a policy is for the insurance company an object of risk technology. On the other hand, for the customers it is a tool with which to be prudent, that is, with which to manage future uncertainty to an extent, although the precise workings of this tool remain unknown; for them, an insurance policy is a prudential technology of uncertainty. Although families do not share the *same* rationalities and knowledge bases as those used by the insurance company, they can be rational in their own way, and on another scale. Following Mol (2002), it could be claimed that the private health insurance policy is *enacted as two different objects*, one by the companies and one by the customers.

Love, moral responsibility and bad conscience

For parents, the feeling of security that they seek by taking out an insurance policy is intimately intertwined with two other strong affects: love and sense of responsibility. It is out of love for one's children and out of responsibility for the family that one has to do all that is in one's might to mitigate future uncertainty. Importantly, similarly to love and health, security does not have an upper limit as to how much of it one can have (Collier et al. 2004, p. 7). Therefore, if it is possible to commoditise these, the market is potentially endless. The success of life and health insurance as a form of industry is fundamentally dependent on this sort of commoditisation, of the 'capture of affect' (Anderson 2011; Cochoy 2004; Deville 2015). However, crucial here is to understand that this does not make the behaviour of the customers, those 'captured', simply irrational. Rather, when using the prudential technology of uncertainty that insurance provides them, *strong affects and rational planning end up intensifying*

each other. An object such as a life or health insurance policy could not be sold if its economic value did not overflow to non-economic modes of valuation (Lehtonen 2014; McFall 2014; Zelizer 1979).

There is a reverse side to security, love and responsibility not having upper limits: one can never be sure about having done enough, given enough or been enough. If a private health insurance policy acquires a position in the middle-class lifestyle where it is self-evidently assumed part of good parenthood, not having it will result in negative feelings. Informants discuss this in the following manner: 'I certainly felt I was being a bad mother when I said that we won't get it for our child. I argued for not insuring the child, and still I did feel a small sting in my heart, had the feeling of being a bad mother.' 'Especially when I was pregnant, well, we got these adverts home. I wondered if I'm a bad parent if I won't have [an insurance policy for the child].' Evidently, for the parents an insurance policy provides a means with which to express one's willingness to care. At the same time, its existence and popularity also create a new layer to the *demands* related to good parenthood. Whether you take out an insurance policy for your child or not comes to be seen as a test of your love.

Part of the reason why the debates concerning private health insurance in Finland can become heated is precisely the affective charge related to the theme. Yet, a person can get a bad conscience not only for *not* taking out an insurance policy but also for *having* taken it out. In one of the focus groups, this was discussed by two women: 'In a way I have a bad conscience for having taken out an insurance policy, because the public health care should be supported, so that there won't be class differences.' 'Me too, I have a very bad conscience because I definitely would not want to visit the private [health care], because I feel that I'm in a different position than those who will have to go and sit at the emergency waiting room. As we all pay taxes, why wouldn't we take care of our public services.' Affects such as love and responsibility can evidently intertwine with affects related to social justice and moral and political ideals and support or limit each other. Moreover, the financial instrument comes to test both your love for your child and your political convictions; and often these two kinds of tests are seen as incompatible.

Overall, the private health insurance policy for children is revealed to be a *mixed object*, made up of a number of heterogeneous elements. As an object, it would not exist if insurance companies were not able to base it on precise risk calculations and economic planning. At the same time, informants show that it amalgamates other items as well. It is made up of affects such as love, responsibility and the feeling of security, but also of the negative relationship with the municipal health centre and queuing practices. In addition, its constituent elements include the economic situation of the household, habituated practice, the family tradition and the lifestyle choices shared with friends. For parents it is a prudential technology of uncertainty, but also a moral tool, in addition to being an economic tool and an instrument for creating convenience. Still, this is not the end of the list. In the next section, I will discuss how the private health insurance policy for children is made up of even more features; namely, for the insurance companies, it is a tool with which to capture clients, and a marketing tool.

Domesticating families

Perhaps surprisingly, insurance companies in Finland do not regard private health insurance for children as a particularly good business. In the discussions with senior actors in the field, it emerges that when the product first became popular in Finland in the 1980s, the price was so low that companies accrued losses from it. Since then the pricing has apparently been corrected. However, as a chief executive officer of one of the biggest life insurance companies in Finland stated in an event in 2015, where the role of private health insurance for children was discussed: 'I don't think there's a company in Finland for whom it's really a business', meaning that for none of them it is a source of substantial profits. Moreover, in terms of revenue, it plays a very small role in relation to all financial activities in which the companies involved are engaged. Why then do the companies continue providing this product? From their point of view, to examine the role of one category of products isolated from others might be quite misleading.

The insiders of industry say that it is difficult to attract new clients for personal insurance or to get people to change companies. In this situation, the capability to secure new clients becomes in itself of high value. Of course, normally people do not spend much time thinking about insurance. This can change in life's turning points. Therefore, expecting a child is also potentially one of the most important points of entry to a household for an insurance company. The company can sell not only a private health policy for the child but also find it easy to persuade the future parents to take out a life insurance policy. While they are at it, they might even consider updating the rest of their insurance cover simultaneously – a practice that is attested by informants.

Evidently, although health insurance for children does not really bring in significant profits for insurance companies, it plays an important role in other respects. In this, its success is related to the limitations in the workings of the market. First, customers are faithful to the companies they originally choose, and they do not always even compare prices. Second, the products available can indeed be difficult to compare, not only because of the technicality of insurance contracts, but especially because they are usually sold as combinations of policies: you get a reduced price the more policies you bundle into one deal. As one of the informants explains, 'We took out insurance policies for us, accident and health insurance, and then we transferred the car insurance to the same company because we wanted to build something where there are enough insurance policies in the same place, so that we get percentages down.' For a consumer, there is a strong incentive to have all financial services in one company. Moreover, as supermarket chains' bonus systems can be linked with these, as well, the optimisation of bonus points by clients can lead to a major capturing effect, as yet another informant explains. 'My wife is attached to the S-group [supermarket chain], so that's how we ended up with If [the insurance company]. Then, we concentrated everything there, so we got terribly high bonus points.'

Third, and perhaps most importantly, acquiring insurance coverage is often linked with the usually biggest financial investment a household in Finland makes: getting a mortgage. For the financial

institutions, this is also a product that matters in terms of cash flow and profitability, in contrast to health insurance policies for children. As everywhere in the OECD countries, in Finland, financial institutions have been merged into huge department stores that offer products in all fields thinkable related to banking and insurance, and they aim at retaining a client for the whole product set. Usually the best rate for insurance is offered by the company where the customer has also taken out a mortgage, and vice versa, a good experience with a company on how it handles children's health insurance can lead to the willingness on the customer's part to favour that company also for mortgage. In fact, in some cases choosing this is not only a case of 'image'. Rather, if a child has a private health insurance policy, and a costly diagnosis has been detected, no insurance company is willing to insure him or her anymore. Hence, the family will be stuck with their original company – and is thus led to give that financial department store priority in the negotiations on the mortgage. In this way, the core themes of the financialisation of daily life literature – mortgages, credit and debt – are revealed to be important also when discussing insurance, as it is income streams from households that finance capital is interested in. It can even be claimed that it is flows of money from households that have been the mainstay of financial expansion and that households serve as the asset base of securities (Bryan and Rafferty 2014).⁹

On the whole, from the point of view of the insurance companies, and the larger financial conglomerates that they are part of, as a product, the private health insurance for children is a sort of lure that helps people become attached to a service provider. As much as a technology of risk, it is a marketing tool with which to capture and tame the wild (everyday) economies of households with children. Families are domesticated into good, faithful customers who seek bonus points.

However, is there not a tautology in saying that family life is 'domesticated', when by definition family life is 'domestic'? The point here is that the 'domestic' should be seen as a dynamic category. What now is tame can run wild again in the future, and vice versa, what is domesticated partly helps to create and

⁹ I thank Lisa Adkins for drawing my attention to this point.

constitute the sphere of things domestic. Importantly, in the contemporary middle-class lifestyle in Finland, for many families a private health insurance has become part of the domestic sphere, an ordinary element in it. Hence, it would be a mistake to regard the economic or financial sphere and the domestic sphere to be in a relationship of externality with each other. Rather, they co-constitute each other, that is, they create each others' contexts (see also Allon 2015; Langley 2008; Olcon-Kubicka & Halawa 2015). What the present study underlines is that this co-constitution cannot be simply presumed to take place in a process where the household itself is a black box; rather, looking into the practices and valuations through which people become engaged with financial instruments shows how the process of co-constitution is contingent, and also dependent on other institutional practices, such as the way in which public health care is organised. Domestication of finance is revealed to be heterogeneous and complex.

A final remark needs to be made on the financial flows related to the private health insurance for children. Families in general have a very positive user experience of this product: it lowers the threshold for seeking a specialist's opinion on health issues, and people appreciate the laboratory services and drug receipts the availability of which it improves. Further, the process of receiving indemnities is described as normally being very fluent. All of these services cost money, and they are included in the policy's price. Therefore, as the services are in a sense prepaid, a family has an incentive to use them. Even more importantly, private health centres, who will be paid for their services by the insurance companies, have very strong incentives for offering them; they have *carte blanche* for suggesting an abundance of services for the customer 'in case of security'. Consequently, while both for the households and for the insurance companies the advantages given by the product are not economic in any simple manner – the product is expensive for the households, yet in itself it does not bring much profit to the companies either – the case is different for the private health centres who make good money with the product: they are the clearest winners of the Finnish middle-class trend of insuring children privately.

Conclusion: the domestication of insurance technology as a set of trials

In this article, I have examined how economic, political and moral valuations become intertwined in the domestication of private health insurance for children in Finland. By way of conclusion, I will recap four key points.

First, I have emphasised that it would be wrong to analyse the acquisition of an insurance policy outside of the everyday relations in which the product is appropriated and tested, and the temporalities involved. The testing activity is multidirectional. A household's relationship to the product is a result of a combination of trials, and even more importantly, a result of them hierarchising different trials. A family will have to ask whether an insurance policy is economically worth the price. Does it really help in the management of everyday schedules, or does it create security? The future parents' relationship is tested when they argue over whether to take out a policy or not. Public services are tested in relation to the quality provided by the private sector. Nevertheless, many also wonder how they should relate to the product's effects on the municipal health centres and the whole welfare state; one's political convictions and moral responsibilities are put on trial. The insurance company, for its part, has to ask whether offering this product is economically viable. Should it be regarded simply as a marketing tool? It will also test particular families' economic situation as regards the potential of being good customers.

What both Latour (1999) and Boltanski and Thévenot (1991) have called attention to is that whenever there is testing, (moral) hesitation and (political) criticism become possible. Following this idea, the multitude of trials involved helps to explain why the private health insurance policy for children can be such a controversial object in Finland. It opens many entry points for a critical attitude, be it against the presumed malfunctioning of the municipal health centres or against what some see as the egoistic attitudes of the middle-class families, considered to be behind the worsening of the public service.

Second, in relation to the broader sociology of finance, it is intriguing how the insurance instrument is, from the point of view of its users, so little about finances. Alternatively, to be more precise, it is predominantly about finances only for those who cannot afford to take it out. The popular product is expensive from the point of view of simple economic calculations. It is those with lesser means who are forced to emphasise these simpler calculations, whereas for others, the judgement concerning the worth of the insurance policy is more multidimensional. In addition, as the cognition in the decision process is distributed within a circle of acquaintances with whom one is bound to share the economic situation, educational background and taste, this process tends to support the product's status as a middle-class thing.

As this article has shown, the private health insurance policy for children in Finland is a *mixed object*, made up of a wide variety of things. These include convenience, family tradition, warm experts who give advice, the moral responsibility of a middle-class parent and affects, such as love and the feeling of security, in addition to calculations of risk or strict economic value. Moreover, while the financial instrument is defined positively as a relationship between service providers, user experiences, or concern for health, among other things, it is also defined by the negative relationship families can have with the public services on offer; the instrument would not exist without the adverse perception of the municipal health care. Because of the multiple relationships in which it can be engaged, the private health insurance policy for children in Finland can be used either as a financial tool, a moral tool, a health tool or, by the insurance companies, a marketing tool.

Third, the product is not only made up of very different kinds of entities and relationships, but also it exists and has effects on *many scales*. Families' concern for health is transformed into tiny monetary brooks that through the insurance companies' activities join the massive global financial flows. Through bonus systems, the policy links children's health care to households' mortgages and, more generally, to their everyday use of money in terms of saving and shopping. Moreover, while the health insurance policy can influence a child's life, and a family's way of using health services, in addition it

affects the quality of service given to those who have not wanted to, or have not been able to, take out these policies. The product is simultaneously a private thing *and* a public problem, because its popularity threatens to aggravate inequality in the face of health risks.

Finally, I have employed the concept of 'domestication' to study the multidirectionality of tests, the mixed nature of the object and the multiscalarity of its existence. The semantic amplitude of this concept makes it especially usable for the analysis of the process where a financial product is appropriated. To talk about domestication implies that there is a wild element that has to be tamed. Something alien becomes familiar. In the present case, this takes place in different ways. To begin with, families give the insurance instrument a shape and existence when they appropriate it to their uses and relations. In addition, the product itself tames chance: it gives the feeling that the uncertain future becomes more manageable for young families. However, simultaneously, in this process, households' everyday life is rendered into something that insurance companies and private health centres can capture, become attached to and control. The process where households domesticate the insurance instrument is simultaneously a process whereby the household itself is domesticated in relation to the financial sphere.

Thus, the concept of domestication is helpful for gaining more insight into how the everyday is financialised. Namely, the domestic sphere should not be seen simply as something that is stable or passive with regard to the active finances; but neither is activity simply on the side of individuals and families. Rather, the category of 'domestic' is dynamic, and its dynamism can be seen to be dependent on processes such as financialisation. Finances and domesticity are *co-constitutive*. Financialisation would not succeed unless its instruments had the capability to capture families' everyday concerns and be attached to them. Simultaneously, the domestication process can lead to a sense of *self-evidence*. Through domestication, financial instruments can become part of our second nature. This has been happening in Finland, as private health insurance for the child has become a more or less self-evident part of the middle-class lifestyle; at least, everybody has an opinion about the phenomenon. Evidently, everyday

life can be financialised, although people active in the process do not think about the process in terms of financialisation.

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